

# [Assessment criteria](https://assignbuster.com/assessment-criteria/)

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Explain the importance of a holistic approach to assessment and planning of care or support The holistic approach is paramount in driving forward the way service users are assessed and implementing the planning for a robust care and support package. Firstly we need to look at what the holistic approach is.

The word holistic derives from ‘ Holism’ which translated means to look at the whole person. So the holistic approach rather than focusing on a specific problem area, e. g. (angina) would take into account all aspects that affect an individual. These aspects can be broken down into five key areas as follows.

Social – This could be the relationship an individual has with someone/group or identify that individual is isolated/ lonely or maybe is a loner and prefers to be on own. Environmental – This ranges from where the person lives or is currently located, financial status, access to transportation, nearby health and shopping facilities. Physical – This could be any adverse health conditions/disabilities an individual may have. Assessment would ascertain all these. Psychological – This would highlight what is going on in their head. E. g. Are they in good spirits/sad. Do they feel they are being treated fairly with dignity and respect? Spiritual – Understanding if an individual had an affinity with a certain faith/religion. Getting to know the individual and where they feel they stand in life.

Describe ways of supporting the individual to lead the assessment and planning process Effective assessment is the key to care planning which produces positive results. The objective of care planning is to identify service user needs and to enable all staff having contact with that service user, directly or indirectly, to have the information they need to support the service user to receive the service which they consider best meets their needs”, and the stages of care planning as: Assessment Documentation Development Choose Plan Record Review, looping back to Assessment.

Describe ways the assessment and planning process or documentation can be adapted to maximise an individual's ownership and control of it When preparing a personal plan of care for any individual it is vitally important that as much information is gathered from family, friends and the individual in order to have an accurate picture of how the individual wishes to be assisted in their care. If the individual is able to communicate on any level they should be involved in all the decisions around their plan of care. It is important to identify each individuals needs and complete a plan in order to meet these needs. Every individual is unique and could have a lifetime of experiences behind them which will affect their plan of care. Individuals have a right to decide how they wish to be cared for and make their own decisions whenever possible.

Care plans are adapted to each individual as a general plan of care would not provide a quality care plan for each person and would not enable the care staff to provide quality care designed for everyone. A care plan is completed and deigned for a specific individual and that care plan is only meant for that one person.

How do you establish with the individual a partnership approach to the assessment process In order to provide an accurate plan of care for each individual it is vital that as much information related to that person is collected previously. The person in which the care plan is related to must be involved in every aspect relating to their plan of care. The care plan would then be completed together in a partnership effort that would provide all the individuals wishes and needs in order for any carer that reads the care plan to have a clear idea of how that individual wishes to be cared for. The care plan needs to be updated every time there is a change or a need changes in order to keep the care plan accurate. The individual needs to be aware that they can change their plan as and when they need or wish to.

How do you establish with the individual how the process should be carried out and who else should be involved in the process Forming a trusting and respectful relationship with the individual helps to complete a plan of care. The individual needs to know that the care plan is private, confidential and unique to them in order for the care staff to provide quality care the way that the individual has asked.

It is also important to inform the individual as much information around how a care plan works and how it assists their carers to meet their daily needs. Only allocated staff have access to this persons plan of care and it is important that the information inside their plan will not be made available to anyone else. Completing a care plan with an individual can be a lengthy process and can take many discussions and time to provide an accurate plan of care. If the individual gives consent other people can add relevant information to their file via allocated staff in order to provide information to improve the picture that needs to develop within their care plan.

How do you agree with the individual and others the intended outcomes of the assessment process and care plan. Conversations and discussions relating to their plan of care will provide the individual and others the intended outcomes of the assessment process and care plan. The individual always has the first choice and decision relating to their plan of care and can be adapted by care staff to provide the quality of care the individual has the right to receive. After the care plan is written and completed but before it is implemented fully the individual has the right to read and accept their plan of care as the way they wish to be cared for. Any changes are to be made as quickly and as soon as possible in order for the care to accurate . The individual can at any time change their mind and re evaluate each need as much as they like.

Family can make these decisions if the individual is not capeable as long as they have the best interest of the individual in mind and relevant professionals have been informed and they have permission to do so. 2. 4 How do you ensure that assessment takes account of the individual's strengths and aspirations as well as needs Gaining history and information around the individual forms the care plan. Liasing with colleagues and family and friends to collect information. Looking at photographs to form a picture of the type of person they are. Discussions with the individual and/or family will provide a more accurate picture of the individuals strengths and aspirations.

How do you contribute to agreement on how component parts of a plan will be delivered and by whom Liasing with colleagues and managers regarding the delivery of care is vital to ensure a safe practice for each individual. Being able to report that a need needs changing or adapting as illness or disability progresses. Following the care plan to the individuals wishes needs to be physically possible and safe and within policies and procedures and guidelines set out by the company. Key workers are usually allocated and senior carers are also allocated to oversee the plan of care for each individual and managers oversee that the care provided is within guidelines and each level of staff can at any time suggest improvements.

How is the care plan recorded.

A file is built retaining all the information collected and is confidential, only allocated staff involved with the individual are allowed access to personal individual information. The care plan is updated on a regular basis (monthly in my establishment) or when the need changes or a new need is identified. [HSC3020. 4] Be able to support the implementation of care plans Assessment Criteria

How do you adjust the plan in response to changing needs or circumstances Regular updates and evaluations are needed to keep a care plan updated. Regular assessments involving the individual are needed to identify changing needs or circumstances. If needs have changed or new needs are identified then the care plan needs to be updated accordingly.

How do you seek agreement with the individual and others about: • who should be involved in the review process Consent to care order must be signed by the individual or representative before any care can be started. Managers, allocated key workers are all involved in the care plan process. The individual must be kept informed of the progress of all areas of the care plan and the care plan can be accessed by the individual or their representative at any time.

The effectiveness is tested on a daily basis through the continuing care of the individual by their cares. Health and safety of all involved is paramount to the effectiveness of each individual care plan. Any concerns must be reported to the managers and the care plan reviewed if found to out of date or dangerous. eg if the individual has become ill or suffered a fall or had a stroke this will affect all areas to the care plan and the care plan will need to be altered to meet the new needs.